

PHILADELPHIA MEDICAL TIMES.

SATURDAY, MAY 1, 1875.

ORIGINAL COMMUNICATIONS.

REPORT OF A COMMITTEE APPOINTED BY THE PATHOLOGICAL SOCIETY OF PHILADELPHIA TO EXAMINE THE SPECIMEN OF IMPERFECT-CYCLOPS MONSTER PRESENTED BY DR. F. H. GROSS.

Read March 11, 1875.

YOUR Committee beg leave to report that upon examination they found that the specimen was an example of the deformation known as the *ethmocephale* of Saint-Hilaire, the exact position of the specimen being, it was thought, in close connection with the cyclops group of monsters.

The body was that of a male child at full term. It presented nothing unusual apart from the head and face, to which your Committee's remarks will be confined.

FIG. 1.



VIEW OF THE HEAD BEFORE DISSECTION.

The forehead was much contracted from side to side, and presented a single frontal protuberance. The palpebral fissures were approximated, each fissure measuring five lines in length, and directed slightly downwards and outwards. The space between the eyes was nine lines in width, and was occupied by the base of the nose. The latter organ was the most remarkable feature of the specimen. It consisted of a tubular proboscis-like organ, which measured eleven lines in length along its upper surface, five lines in length along its lower, nine lines in width at the base, and five and a half at the tip. It was flexible, covered throughout with integument, presented a single sub-rounded nostril, having somewhat tumid margins, which, towards the middle, both above and below, slightly projected. The

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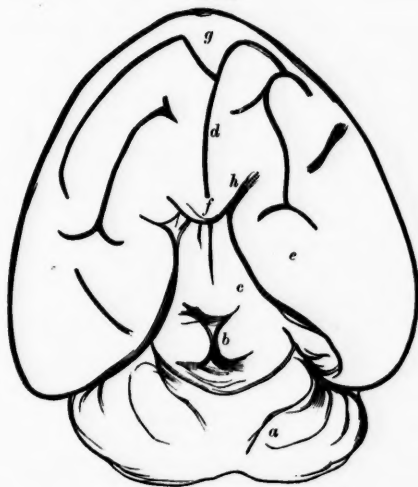
interior of this organ appeared to be a *cul-de-sac*, without communication with the mucous membrane.

The lips were well formed, the oral fissure measuring ten lines in length. The upper margin of the fibres of the orbicularis oris muscle was defined by a well-marked wrinkle. The space between this and the base of the nose was smooth, measured nine lines in height, and was continuous with the cheek-surfaces.

Upon removing the calvaria, it was found that the brain-case was not entirely occupied with the brain, the top of the cerebral hemispheres failing to reach the sagittal suture by one inch. Its appearance was, moreover, remarkable by the failure of the posterior cerebral lobes to overlie the cerebellum. The sides of the longitudinal fissure at its posterior part were widely divergent, disclosing the *velum*. The space not occupied by the brain was filled with a thin serous fluid. The dura mater sent no folds between the encephalic masses; so that the great falx and tentorium were absent. There was, of course, no longitudinal sinus.

When the brain was removed, the dura mater was seen lining the base of the skull in the usual manner, so far as the posterior and middle cerebral fossæ were concerned. That lining the anterior cerebral fossa presented a smooth surface, not interrupted by any eminence which would indicate the position of the *crista galli*. The transverse diameter of the anterior cerebral fossa was one inch and ten lines. There was no appearance of olfactory grooves or cribriform plate.

FIG. 2.



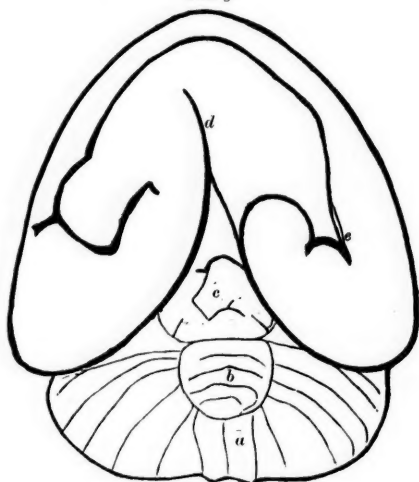
THE BRAIN VIEWED FROM ABOVE.

a, the cerebellum; b, corpora quadrigemina; c, probable position of the optic thalamus; d, the median sulcus; e, the occipital lobe; f, the first posterior transverse convolution; g, the first anterior transverse convolution; h, the parieto-occipital fissure.

Viewed from above (Fig. 2), the encephalon presented the following appearances: The cerebellum (a), corpora quadrigemina (b), and optic thalami (c) were exposed; the cerebrum terminating four lines in advance of the cerebellum. The cerebrum was imperfectly divided into two hemispheres. The longitudinal fissure was represented by a median

sulcus (*d*) measuring nine lines in length, which did not extend downwards to a corpus callosum, —this commissure being entirely absent; nor did this sulcus differ in any respect from those elsewhere seen on the cortex. The occipital lobes (*e*) were not approximated; indeed, it was by their want of approximation that the optic thalami and corpora quadrigemina were seen.

FIG. 3.



THE BRAIN VIEWED FROM BELOW.

a, medulla oblongata; *b*, pons Varolii; *c*, infundibulum; *d*, inferior median sulcus; *e*, fissure of Sylvius.

Viewed from beneath (Fig. 3), the encephalon presented a normal medulla oblongata and pons. There were no mammillary bodies. The under part of the mass, answering to the conjoined thalami, (?) presented a conspicuous infundibulum (*c*). The posterior perforated space was absent; the two anterior were conjoined into a central space placed in advance of the infundibulum. In front of the latter space was a median sulcus, measuring seven lines in length. The olfactory nerves were absent. The position of the optic tract was obscurely defined. No trace of a chiasm was seen.

The general aspect of the cerebrum led your Committee to determine the significance of its malformation to be as follows: that at an early period in the history of the foetus, at a time when the hemispheres were about to be discerned, the development of the mass was arrested. A decided attempt at a symmetrical division of its parts was announced, which, however, was not successfully attained in many parts of the cerebrum: thus a right and a left hemisphere were recognized, united by two conspicuous transverse convolutions in front, and by two shorter and less conspicuous convolutions behind. The superior median sulcus was terminated posteriorly by the first posterior transverse convolution. The first anterior transverse convolution presented upon its upper margin a pyramidal offset, which abruptly arose, and was lodged within the superior sulcus, bifurcating it in front.

In the right cerebral hemisphere the fissure of Sylvius began about a line above the level of the anterior perforated space, and ascended less than half the way up the side of the hemisphere. In

front of this fissure were the transverse convolutions, the fissure joining the sulcus between them. Behind it was a large smooth surface which answered pretty

FIG. 4.



PROFILE VIEW OF THE BRAIN SEEN FROM THE RIGHT.

a, anterior superior transverse convolution; *b*, superior median sulcus; *c*, the posterior superior transverse convolution; *d*, the parieto-occipital sulcus; *e*, the occipital lobe.

nearly to the posterior half of the hemisphere. The fissure of Rolando began at the anterior border of the superior median sulcus, with which it was continuous, and extended downwards and outwards to the end of the first anterior transverse convolution. The position of the parieto-occipital sulcus was marked by a wide fissure, bounded in front by the posterior superior transverse convolution, and behind by the occipital lobe.

FIG. 5.



PROFILE VIEW OF THE BRAIN SEEN FROM THE LEFT.

a, parieto-occipital sulcus.

The left cerebral hemisphere presented a fissure of Sylvius which began at the level of the anterior perforated space, and did not ascend the side of the hemisphere, but was deflected forwards and inwards, to be continuous with the sulcus between the two anterior transverse convolutions.

The fissure of Rolando passed outwards and backwards, not parallel with the median sulcus, but outwards along the side of the hemisphere to the first anterior transverse convolution. The parieto-occipital sulcus was less deep than that on the right side, but wider. About the posterior third of the hemisphere, below, and at its sides, no convolutions were seen.

These features represented, it was thought by your Committee, the most important points of the superficies. Of minor value would appear to be the presence of a conspicuous sulcus upon the upper surface of either hemisphere, which on the right side joined the fissure of Rolando in front and at its termination, and extended backwards and nearly parallel to the median sulcus, to terminate in the occipital lobe by a Y-shaped flange. A similar sulcus on the left side had no connection with the fissure of Rolando anteriorly, but extended back-

wards and outwards to terminate in a similar manner with that of the right side.

Two other sulci were seen, which were not symmetrical: the one on the right was a little depression about the middle of the side of the hemisphere; the one on the left, somewhat larger, seen upon the upper portion of the occipital lobe.

It will be observed that all the parts are better developed upon the left than upon the right side.

The interior of the cerebrum was a simple cavity, without any attempt apparent at the formation of *fornix*, *corpus callosum*, or *septum lucidum*. No prolongations were seen in the position of the olfactory nerves. Posteriorly, the cavity was continuous, with a cul-de-sac about seven lines in depth, apparently formed by the doubling of the cerebral tissue at that point; and the fold thereby made determined the posterior inferior border of the hemisphere. This cul-de-sac your Committee took to be in the position of the future middle horn of the lateral ventricle.

A longitudinal section of the skull was made a little to the right of the median line; yet so narrow was the pre-sphenoidal portion of the body of the sphenoid bone that the section was directed through the right optic foramen, where an optic nerve was found in position.

FIG. 6.



PROFILE VIEW OF THE IMPERFECT INTER-ORBITAL SEPTUM SEEN FROM THE LEFT.

a, the frontal bone; b, the ethmoid bone; c, the lachrymal bone; d, the superior maxilla.

An osseous column was now displayed, which extended in the median line from the frontal bone to the intermaxillary bone, and which was thought to answer to the associated ethmoid and lachrymal bones. No trace of the vomer could be found. The above mass measured six lines in height, six from behind forwards, and three in width. It formed an imperfect septum between the orbits, which served to separate these cavities anteriorly only, while posteriorly the eyeballs were surrounded by a common mass of fatty tissue and muscle.

The section exposed the dental sacs. The left half contained almost the whole of the palate, presenting anteriorly an intermaxillary bone, the outline of which was well marked on the upper or orbital surface. This surface terminated in an ante-

rior nasal spine. This latter process was much more pronounced than is normal, or rather the intermaxilla was deeper than normal, by which the process in question was raised above the level of the orbits. The outer walls of the orbits were normal. The floor was common to both, and was formed by a coalescence of the orbital plates of the superior maxillæ with the intermaxillæ. The infra-orbital canals were in position.

The hard palate terminated posteriorly in a normal velum. There was no room for the posterior nares: in fact, in their place was found a mere pouch of mucous membrane between the two pterygoid processes, extending below into the velum and above into the roof of the pharynx. The Eustachian tubes were in position. At the line of junction of the nasal columns with the frontal bone (Fig. 6, a) there was on either side a foramen transmitting a nerve which was traceable into the cranial cavity. Your Committee would take this nerve to be the nasal branch of the ophthalmic. This fact alone led them to conclude that the upper portion of the septum consisted of the ethmoid bone (b). The latter structure presented in the median line an imperfectly developed vertical plate, and on either side, appearing respectively in the right and left orbits, was an irregular mass of bone, which represented the lateral mass. This articulated above with the frontal bone, and below with the lachrymal (c) of its own side. Each lateral mass inclined towards its fellow, so that the two touched behind their entire length, forming the posterior free edge of the upper half of the column. The plates were also approximated in front, at their upper portions, but were slightly divergent below, to define, with the aid of the lachrymals, an opening which answered in position to the nasal chambers, within which was seen the lumpish perpendicular plate. The lower bone of the septum on either side was undoubtedly the lachrymal. It presented on its outer surface a marked groove which was completed by the ascending portion of the intermaxillæ. On the left side the groove was better marked, the posterior inferior angle of the bone being prolonged into a hook-like process which was attached by ligamentous union to the upper surface of the intermaxillæ. The anterior inferior angle of the bone was attached to the nasal spine of the intermaxillæ. The lachrymal bones converged and touched behind, to form a sharpened edge, which constituted about the lower half of the posterior border of the nasal column. Anteriorly, the bones aid in defining the lower portion of the lateral walls of the nasal chamber. The integument lining the proboscis-like organ was evidently continuous with the true skin-surface, but had united with the parts above described so far as to have entered and been held in close connection with the interior of the rudiment of the nasal chambers.

The thoracic and abdominal viscera were normal. A section of the lungs floated in water.

F. H. GROSS,
JNO. GUITERAS,
JNO. M. KEATING,
HARRISON ALLEN.

A CASE OF ATRESIA VAGINÆ.

BY H. S. SCHELL, M.D.

Read before the Pathological Society of Philadelphia.

ON the 2d instant an Irishwoman named Mary G. was admitted to St. Mary's Hospital, on account of a painful tumor of the abdomen. She was 30 years of age, and had been married five years. The hypogastric region was filled with a round body about the size of the womb in the fourth month of pregnancy.

From this mass an oblong tumor, about six inches long by two and a half inches broad, extended obliquely into the left lumbar region, and was movable from side to side to the extent of a couple of inches. Both of these bodies were rather hard, tense, and elastic. The patient stated that she had never menstruated, but that she had suffered from abdominal pains at monthly periods for the last twelve years. She had noticed the tumor for the last five years only. She was now scarcely ever entirely free from pain, and she anticipated the monthly exacerbation in a few days after her admission. On attempting to make a per vaginam examination, it was found that the canal was apparently somewhat in front of its usual position. It grasped the forefinger closely, and curved round immediately behind the os pubis. It was dilated at its upper part about the tip of the finger, but no os uteri could be felt.

The tumor was encountered at two and three-quarters inches from the external orifice. The rectum was large and flaccid. It dilated, immediately after passing the sphincter, into a sort of pouch. Its anterior wall was in contact with the perineum, the apparent vagina, and the base of the tumor, and, finally turning off to the left, was lost to the touch.

Visual inspection of the external organs of generation revealed well-formed labia, nymphæ, and clitoris. No normal urethra could be found, but when the finger was withdrawn from the anterior canal it was followed by a few drops of urine. The perineum was unmarked even by a dimple. When a finger was introduced into the anterior canal, and another into the rectum, there was evidently only the thickness of the walls of the two passages between them. No fibrous cord could be detected, and the coats of the two canals could be made to glide upon each other to some extent.

It seemed to me probable that this was a case of absentia vaginæ; that the large tumor consisted of the uterus distended with retained menses, and that the movable offshoot might be a Fallopian tube enlarged from the same cause.

On the 7th instant, at the probable monthly period, the woman suffered such extreme pain in the tumor that it was found necessary to resort to the hypodermic use of morphia to render her condition tolerable. As she was exceedingly anxious to be relieved, I proposed to make a vagina by incision in the perineum and careful dissection of the urethro-rectal septum, and to let out the retained menses.

On the 14th, a week after the monthly period, in consultation with Drs. Keen and Mears, it was decided to etherize the patient, and make, if pos-

sible, a more thorough examination before operating. The woman proved to be very refractory to the influence of the ether, and the consumption of a pound only produced incomplete anæsthesia, during which she made violent expulsive efforts. In one of these, a large portion of the tumor, about the size of a child's half-born head, was forced for a moment through the anus.

During the examination, the length, large size, and natural appearance of the anterior canal produced some doubts as to the correctness of the previous diagnosis. It was thought that it might be a common duct for the bladder and uterus. To this uncertainty was added the fact that the proposed operation was of a delicate character, and a fatal result from it not impossible. Under the circumstances it was decided to use the aspirator,—1, to ascertain the nature of the contents of the tumor; and 2, if found to be menstrual fluid, to relieve the uterus of most of it; and to make the proposed dissection at some future day, if thought desirable.

The puncture by the aspirator was accomplished through the rectum by means of the smallest needle, and two or three drachms of thick, slimy, red fluid removed.

It was then found that the joint between the needle and the rubber tube was not quite air-tight, so that the fluid could only be withdrawn slowly and with great difficulty. The needle was therefore removed from the tumor, with the intention of having the instrument made perfect and of taking away the rest of the fluid in a few days. The next morning, however, found the patient laboring under a violent attack of general peritonitis, which resulted fatally, in spite of treatment, on the evening of the 16th.

A post-mortem examination, made the following day, showed that the peritonitis had been caused by the diffusion throughout the abdominal cavity of the menstrual fluid previously contained in the tumor. What remained of the hypogastric tumor was now a flaccid, nearly empty sac, capable of holding about a quart. It proved to be the occluded and distended vagina. Its walls were one-fourth of an inch in thickness, except in the Douglas's cul-de-sac, where for a couple of square inches they were thin as paper. In the lower part of this attenuated region the fatal rupture had taken place, the rent being only large enough to admit an ordinary probe.

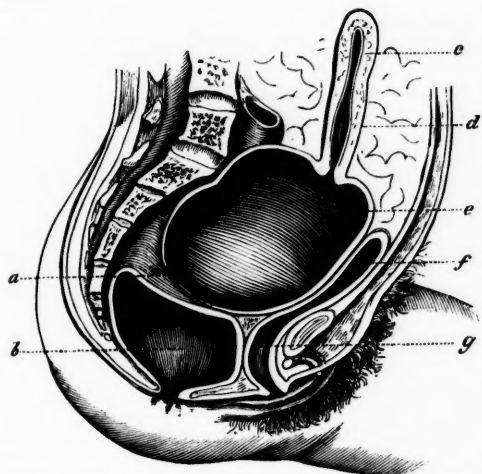
The body in the left lumbar region was found to be the hypertrophied and elongated uterus. It measured five inches long by two and a quarter inches broad. Its interior was divided into two unequal cavities, of which that of the neck was perhaps treble the capacity of the body. The walls of the organ varied in thickness from three-fourths of an inch in the body to half an inch in the cervix. The cavity contained about a fluidounce of menses, and communicated with the vaginal pouch by an orifice similar to that of the virgin uterus.

The right Fallopian tube was normal in its origin, and its distal extremity was dilated so as to hold an ounce or two of fluid.

The left tube had an irregular origin near the internal os uteri. The apparent vagina proved to

be the urethra. It was three and a half inches long, its walls thick and muscular, and it led to the bladder only. The walls of the latter were thickened and its mucous membrane congested. The fluid removed by the aspirator and also that taken post-mortem from the uterine and vaginal cavities showed under the microscope a large quantity of granular detritus, some mucus- and blood-corpuscles, and numerous crystals of cholesterin.

It was impossible to find in the rectum or vaginal pouch any trace of the passage of the aspirator-needle.



b, rectum; c, uterus; d, cervix uteri; e, vaginal sac; f, bladder; g, urethra; a, point of rupture of vaginal sac.

In the accompanying drawing I have endeavored to represent as accurately as possible a sectional view of the condition of the parts previous to the rupture of the tumor. An examination of this diagram suggests the theory that at the age of puberty the vaginal pouch was probably not far from the perineum; but as the menstrual fluid accumulated the sac gradually rose from the pelvis into the abdomen, dragging with it the rectum and urethra, the latter becoming elongated and hypertrophied to accommodate itself to the new relations of the parts, and its capacity being enlarged perhaps by *intromissio penis*.

The rectal dilatation is not so readily accounted for, but it is possible that it may have officiated vicariously in the performance of marital rites.

It is difficult to determine in this case precisely when the rupture of the vaginal sac took place; whether it was produced by the pressure used in making the examination by the puncture of the needle, or by the expulsive efforts of the woman herself. The possibility of such an occurrence was contemplated before the examination was made, and much care was taken in manipulating the parts, so that it seems improbable that this could have caused the trouble.

As to the implication of the needle in the disaster, my object was to make the puncture anterior to Douglas's cul-de-sac, so as to avoid the peritoneum if possible; and I think I succeeded. I am therefore disposed to attribute the accident to the

patient's bearing-down efforts, which were mostly reflex in their character, and caused by the introduction of a foreign body—viz., the finger or sound—into the congested and irritable bladder.

This view is rendered more probable by the fact that when the puncture was made, about five minutes after the most violent effort, the impression produced upon my mind was that the tumor was softer and farther away from the perineum than it had ever been before. At all events, in consequence of the excessive thinning of the posterior vaginal wall, a rupture at that point was imminent at any time.

The case is instructive as displaying in an unusual manner the peculiar danger of this malformation, and teaches a valuable lesson as to the propriety of an early operation.

PHILADELPHIA, February 27, 1875.

The specimen was referred for examination to the Committee on Morbid Growths, which reported, March 25, as follows:

"In Dr. Schell's specimen of congenital occlusion of the vagina, your Committee have found the black coloration of the walls of the pouch due to presence of hæmatoidin crystals and pigment-granules in the submucous and connective-tissue layers of the dilated vaginal canal. This coloring-matter has unquestionably been absorbed from the retained menstrual blood.

"The walls of the uterus are slightly thickened; there is, however, no dilatation of the uterine cavity proper, simply a funnel-shaped distention of its cervical canal. The absence in this specimen of hæmatometra, so generally an attendant upon congenital atresia of the genital canal after the establishment of menstruation, seems to your Committee explicable upon the fact that in this case the ante-flexion of the uterus, with the ensuing kinking of the organ at the internal os, has acted as a mechanical hindrance to its further distention.

"The manner in which the uterine cavity has been laid open prevents us from ascertaining whether a complete stenosis existed at the internal os. The urethra very readily admits the insertion of a finger."

NOTES OF HOSPITAL PRACTICE.

PHILADELPHIA HOSPITAL.

A CASE OF DOUBLE MONSTER.

Reported by Dr. E. E. MONTGOMERY.

M. K., æt. 20, a strong, healthy German girl, unmarried, went into labor at full term on the morning of April 5, 1875. The first part of her labor was characterized by feeble, irregular pains. I was called to see her at nine o'clock in the evening. At this time the os was dilated to the size of a common half-dollar, the membranes had ruptured, and the head, covered by the womb, was presenting at the inferior strait. An anodyne was administered, after which the patient remained comparatively quiet until nine of the next evening; at this time the pains became more frequent. Upon examination, I found the os well dilated and the vertex presenting in the first position.

Although from this time the pains were powerful, the

progress of the labor was slow. Shortly after ten, the child's head emerged from the vulva, and labor again stopped. Drs. Edwards and Deaver attempted to stimulate contractions by making gentle pressure over the uterus, while I delivered the shoulders. After the delivery of the shoulders and the upper part of the body of the child, it made no progress, though the pains were severe and I made considerable traction upon the child. Finally passing my finger along its back until I reached the buttock, I in this way succeeded in delivering the lower extremities. The body of the child was held closely to the vulva by the umbilicus. We supposed we were dealing with a case of short cord, and were further confirmed in this belief by seeing a mass lying in the vulva which looked like a portion of the placenta. After waiting a few minutes, endeavoring to resuscitate the child, I introduced my hand to bring away the placenta, and came in contact with the foot of another child. This second child was rapidly delivered with its back to the pubes. The after-birth came away within ten minutes.

Neither child showed any signs of life. The head of the second was pretty well crushed by the contractions of the uterus.

The children, both males, together weighed ten pounds and four ounces, and were connected at the umbilici by a band three inches in length. Near the bodies this band was constricted, but at the centre it was seven inches in circumference, and contained a portion of the intestines. At each side the band was covered with integument to the distance of an inch, while at the under portion the integument extended across. Neither child had a perforate anus. The genitalia were well developed, as were the lower extremities, excepting a contraction of the muscles of the right leg of the first child, turning the heel in and the bottom of the foot upward.

The placenta was large, but presented no separation; the cord, which consisted of two arteries and two veins, came off from its centre. The membranes of the first child covered the whole foetal surface of the placenta, while those of the second arose from the placental end and surface of the cord, and consequently were enveloped by those of the first. The membranes of the second child were apparently a reflexion of those of the first, thus placing the child without, instead of within, the membranes.

Upon inquiry, the mother says that when she was four or five months pregnant she fell, and, as a result of the injury, her menses returned, and continued regularly until her delivery.

Assisted by Dr. Edwards, I made sufficient dissection, without destroying the band, to demonstrate the circulation and the connection between them. The umbilical cord, three inches from the children, bifurcated, and, entering the band, had a portion directed towards each child.

The circulation in the two children is the same. The vein entering the umbilicus takes its usual course to the liver; the abdominal aorta gives off but one hypogastric artery, which, passing out at the umbilicus, becomes the umbilical artery. The peritoneal surface of one was continuous with that of the other through the umbilical openings. The greater portion of the small intestines was in the abdominal cavities, but the ilei pass through the umbilical openings to the common sac, where they join to form a triangular reservoir or receptaculum an inch and a half in length by an inch in breadth at the base, which is continued by small intestines to the cæcum.

This union is some three inches from the cæcum. The latter has two appendices well developed, one on each side of a layer of peritoneum. The common large intestine terminates at the lower portion of the band in

a large pouch, which opens by a small slit-like aperture into a sulcus. This sulcus, beneath the peritoneal surface, extends from the body of one child into that of the other.

As the external genitalia were well developed, we supposed the urinary apparatus perfect, but found the urethrae closed within one-fourth of an inch of the meati, and no indication of the development of a bladder in either. On raising the ureters and introducing a probe, we found it to emerge from the sulcus at either side of the anus.

ALLGEMEINES KRANKENHAUS, VIENNA.

SERVICE OF PROF. CARL BRAUN, MARCH 23, 1875.

TWO CASES OF DUPLEX UTERUS—PREGNANCY—RETAINED MENSTRUATION—DEATH—POST-MORTEM.

ON the morning of November 27, 1874, a patient, about 26 years of age, primipara, was admitted to the obstetrical department of the Allgemeines Krankenhaus, and, having had for some hours labor-pains, was transferred to the ward assigned to patients in labor. She was at once taken charge of by a student, who proceeded, according to the usual method adopted here, to ascertain the position of the child by palpation and auscultation. The irregular outline presented by the abdomen, however, deceived him, and he diagnosed a transverse position.

As Professor Braun made his morning visit, his attention was called to the case, and he at once proceeded to make an examination.

Inspection revealed a large tumor on the right side, running up from the symphysis and Poupart's ligament in an oblique direction, and having its base to the right of the umbilicus. This tumor had, in form and extent, the appearance of a pregnant uterus at full term. Its right and upper borders could be distinctly felt and outlined, while it was movable in the peritoneal cavity. Palpation revealed the presence of a body within the tumor, and, on auscultation, the foetal heart-sounds were readily perceptible. The left border of this tumor, at a point three inches below the umbilicus, was found to merge in another of about one-half its size. Examination showed it also to have an origin in the median line, while its fundus lay to the left of and a little beneath the umbilicus. It was very elastic to the touch. The body and fundus were quite movable, and it might have been pronounced, by an inexperienced diagnostician, an ovarian tumor having an attachment to the uterus on its left border. Attention to this tumor during the occurrence of labor-pains showed it then to be much harder and more resisting than between the periods of uterine contraction, so that there was a resemblance, not only in form, but apparently in function, between the tumors on the right and left sides of the abdomen.

On vaginal examination, a septum was found in the cervix running antero-posteriorly, and the case was diagnosed as one of duplex uterus. All attempts to discover any body in the left horn were fruitless.

The case was then left under close observation for four hours, and, at the expiration of that time, brought into the clinic. Inspection and palpation then showed no special change to have taken place. The amniotic fluid had not yet escaped, but labor-pains had become more frequent and stronger. The contraction of the right horn of the uterus was still invariably found to be attended by a contraction of its fellow on the left. Vaginal examination was repeated, and the head having descended, the position being L. O. A., it was found to be impossible to detect more than a single cavity in the cervix. The septum previously detected had either been ruptured, or the contraction of the right horn of

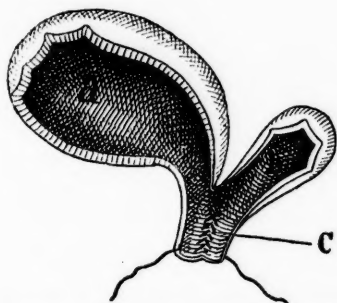
the uterus had so altered the relations of the parts, by forcing the head downward, that the left cervical canal was obliterated and driven backward and upward out of reach.

Professor Braun did not consider the case as demanding any assistance, and the patient was transferred to the ward.

Some time afterwards, a change in the form of the abdomen was observed, and on examination it was found that the child had been driven through the ruptured septum into the left uterine horn. In a short time delivery was accomplished: child still-born. The patient seemed exhausted, and fears were entertained that pyæmic symptoms might manifest themselves, on account of the large surface of lacerated tissue due to the rupturing of the uterine septum. On the day following, a rise in temperature and pulse indicated the correctness of this view. Her condition continued very critical for two weeks, when an attack of pleuro-pneumonia complicated it, and the patient died on the 19th of December, twenty-two days after delivery.

The post-mortem examination showed that subinvolution had but very imperfectly progressed, the right

FIG. 1.



horn (a), the seat of impregnation, being about as large as a child's head at the seventh month of utero-gestation, while the left was twice as large as the normal uterus. The uterine tissues were infiltrated with pus, which was also found in the uterine veins and Fallopian tubes. Traces of the ruptured septum (c) were distinctly observable, extending from the os externum to a point marking the junction of the right and left horns.

In a case of duplex uterus previously occurring here, the left horn, non-impregnated, being caught under the projecting promontory of the sacrum, impeded the course of labor. By steady and persistent pressure it was forced upward, and delivery was accomplished without further difficulty.

The second case was that of a young woman who presented herself at the clinic of Professor Braun, January 21. She complained of having been frequently troubled with dull aching pains in the pelvis; but her appearance, far from indicating any severe or protracted suffering, was that of a person enjoying the best of health. The pains she spoke of were more severe at the menstrual epoch, and sometimes almost insupportable. The menses were regular in their occurrence, moderate in quantity, and lasted the usual time. They had first appeared about two years before, and until then she had never experienced any difficulty. With each recurrence of the same, however, the pain increased in intensity, and she was very desirous that something should be done to alleviate her suffering.

External examination proved the presence of a tumor situated just below the pelvic brim, on the left side. It was round, hard, and inelastic to the touch, and about three inches in diameter. Vaginal examination also revealed the same tense resisting body, without fluctua-

tion, descending below the vaginal extremity of the cervix, and involving it. The uterus was thrust away from the median line to the right. The sound was introduced two and one-half inches, gliding off to the right on entering the cervix in the direction of the fundus uteri.

Upon considering the history of the case, the symptoms, and the results of the examination, Professor Braun stated it to be his opinion that the case was one of intra-mural fibroid involving the left wall of the uterus and also that of the cervix.

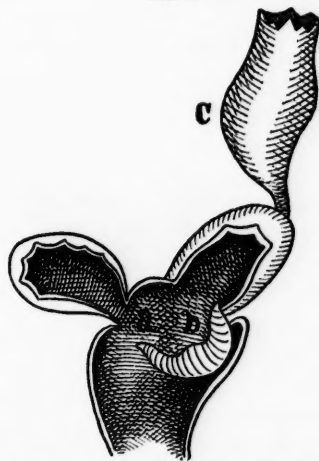
The patient insisting upon some operation for relief, it was decided to proceed to operative measures at once. The operation by enucleation was considered most advisable, and, as a large portion of the tumor descended into the left upper portion of the vagina, no special difficulty was anticipated. An incision through the cervical surface of the tumor was determined upon, its enucleation, as far as possible, by the hand, aided by instruments if necessary, and subsequent extraction by means of the craniotomy forceps.

The incision, about one and a half inches in length, was made in the tumor, when, to the surprise of all present, a dark, bloody, tenacious fluid poured forth from the opening. Professor Braun, at once convinced of the nature of the tumor by the appearance of the fluid, immediately pronounced the case to be one of duplex uterus, with congenital atresia of the external os on the left side and consequent damming up of the menstrual secretions. The tumor, which had presented the physical signs of a fibroid, was the very greatly distended left cervix, its walls being also much hypertrophied. The left horn of the uterus was thrust downward and backward into the pelvis, and had escaped the observations which had been made per vaginam.

The patient was carefully removed to bed, and every attention bestowed which it was thought would avert any serious result; but despite all treatment the temperature rapidly rose on the day following, other symptoms of peritonitis set in, and she died on the 25th, four days after the operation. The peritonitis was due possibly (may it not be said probably?) to blood forced into the peritoneal cavity through the left Fallopian tube.

On post-mortem examination, the right horn of the

FIG. 2.



uterus was found of normal size and healthy, the left considerably larger than the right, but its tissue also healthy; the cervix of the latter (b) nearly spherical in form and exceedingly dilated, being, as already mentioned, about three inches in diameter. Through the incision (a) which had been made in the operation, it opened into the cervix of the right side. The left Fallo-

pian tube (*c*) was long and greatly distended, being nearly two inches in diameter, and filled with a brownish, bloody fluid, adherent to its walls and similar to if not identical in character with that which exuded from the cervix when pierced. The ovaries were large, and the right one exceedingly interesting on account of the remarkable development of the Graafian follicles.

Professor Braun stated that during an experience of thirty years, during which more than one hundred thousand patients had been under his care in the hospital wards, and a large number had been treated by him in private practice, he had never before met with a case of congenital atresia of the *external os uteri*. A few such cases are reported in the literature of gynecology.

G. WILDS LINN.

TRANSLATIONS.

THE NERVI VASORUM OF THE ARM.—In Reichert and Dubois-Reymond's *Archiv* for February, 1875, Hermann Frey (Medical Student) communicates the results of his study of the gross anatomy of the nervi vasorum of the upper extremity. After careful dissection of a number of subjects with this end in view, he feels warranted in making this contribution to an almost entirely neglected point in anatomy.

Like the larger nerve-trunks, the nervi vasorum run as directly as possible to their destination; in their course deriving support and protection from their proximity to the strong sensor and motor nerves, which invariably accompany the arteries and generally the veins. The rule that an artery is supplied by its accompanying nerve does not, however, limit its nervous supply to one source, but it may be innervated in different portions of its course by different nerves. Nor is a vessel necessarily supplied by its largest accompanying nerve: it may depend wholly or in part upon some smaller branch; thus, the first collateral branch of the ulnar is innervated by the ulnar collateral branch of the radial, and not by the ulnar, by whose under side it runs to the elbow-joint.

The afferent nerves enter the vessel always at an acute angle, and should a portion of the vessel-wall immediately surrounding the point of entrance not be supplied directly, a recurrent branch is always given off, for this purpose, from the first subsequent division of the nerve. In no case was seen a short branch breaking immediately into fibres to be distributed upon the surface of the vessel, as has been described by D. Lucae;* on the contrary, a branch will accompany the vessel for some distance before entering its wall. The distribution of a nerve is generally in one plane,—i.e., if a supplying nerve runs along the superficial aspect of a vessel, it will continue thereupon to its terminal division (macroscopic).

The nerves accompanying the superficial veins are small, both on account of their structure and the facility of obtaining branches from the subcutaneous nervous mesh-work that envelops the entire arm. The cephalic vein, however, is an exception; in its upper portion it is accompanied by a branch of the posterior cutaneous nerve from the radial, to which it owes its innervation. Only one case was seen in which a plexus was found surrounding a vessel, and this was the basilic vein.

The arteries and their accompanying deep veins are furnished with larger and longer nerves, and their supply is generally taken from the nearest trunk. Thus the brachial, in the arm, is supplied by the median nerve; in its upper portion it is innervated by a branch from the brachial plexus; below its division we find that the ulnar artery and vein are accompanied and supplied

by the ulnar nerve. The radial artery, from its origin, runs a short distance without any accompanying nerve before it meets the superficial branch of the radial; to supply this defect a small branch is sent from the median.

As regards the nature of the nervi vasorum, Lucae considered that they were paler and more gelatinous than the other nerves; but they appear to differ in no respect from nerves of different function of similar size and occupying similar protected positions.

The individual anatomical observations are briefly as follows:

The cephalic vein, in its upper portion, is supplied by a branch from the posterior cutaneous nerve from the radial, which accompanies it to the clavicle.

The basilic vein is innervated, as a general rule, partly by the smaller internal cutaneous, and partly by the greater internal cutaneous.

The brachial artery obtains, in its upper portion, a nerve from the brachial plexus; in its lower portion it is supplied mainly by the median nerve, but branches are also returned from the ulnar and radial nerves for its use. A comparatively long branch from the median seems to be quite constant, and runs between the artery and vein on their under side.

The radial artery, in its upper part, is supplied by a branch from the median; lower down, by the superficial ramus of the radial, by means of short branches which enter, without much division, directly into the vessel-wall, principally from its superior aspect.

In the ulnar artery belongs a comparatively large nerve, which was in two instances seen to terminate upon the vessel, and hence is a true nervus vasorum. In one case, this nerve lay upon the vessel; in another, it ran across to the volar side, to take its course along the radial aspect to the wrist-joint; in another, it wound spirally around the vessel to attain the same point.

The superficial palmar arch is supplied sometimes from the ulnar, sometimes from the median, by short branches which enter the vessel from above.

The deep arch is always supplied by the deep ramus of the ulnar.

The arteria pectoralis major is supplied by the nerve of the same name; and the arteries for the pectoralis minor, deltoid, and supra-scapular muscles are also supplied by nerves of corresponding names.

The scapular circumflex artery and vein are innervated by the superior branch of the thoracico-dorsalis.

The first collateral branch of the ulnar has a branch not from the ulnar but from the radial (Wenzel-Gruber).

The interosseous artery and vein derive their supply from long branches of the interosseous nerve. The perforating branches of these vessels are innervated by the deep ramus of the radial nerve.

A plate exhibiting the different methods of innervation of the vessels and the distribution and termination of the nerves accompanies and illustrates the article.

F. W.

MUSTARD FOOT-BATH IN URTICARIA.—A writer in the *Tribune Médicale*, March 7, recommends the use of the mustard foot-bath in cases of urticaria. In his own case, after trying innumerable remedies, he was about to abandon all hope of relief, when, one day, while suffering from a peculiarly aggravated attack of his old enemy, complicated by an excruciating headache, and hoping to relieve the latter, he plunged his feet into a mustard-bath. The relief was instantaneous, and it seemed as though the skin-disease had disappeared by a wave of the hand.

Five other cases were subsequently treated by the writer, with similar relief. The treatment is, of course, understood to be only palliative, and has no influence in preventing recurrence of the disorder. X.

* Reil's Archiv für Physiologie, 1809.

PHILADELPHIA MEDICAL TIMES.

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MEDICAL AND SURGICAL SCIENCE.

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EDITORIAL.

THE SO-CALLED SYMPATHETIC NERVOUS SYSTEM.

THERE is an old saying that "Truth crushed to earth will rise again;" but the trouble with error often seems to be that human power cannot crush it. For many years the so-called sympathetic nervous system has been the ever-ready slop-shop of the baffled pathologist, out of which he has drawn ready-made explanations for all the more recondite diseases of the human system. To be sure, the garments often did not fit very well, and the winds of controversy swept through their numerous rents with chilling force, yet to many minds a sham seems better than the open nakedness of confessed ignorance. Recently those imaginative children of the present—the electro-therapeutists—have also availed themselves of this mysterious entity, and by galvanization of the sympathetic have cured all manner of human ills, almost making, according to their own reports, the blind to see, the deaf to hear, and the lame to leap as a hart. If, however, there be anything at all established by modern investigations, it is that the sympathetic nervous system is a human invention; yet teachers and writers still continue to wrap themselves in the tattered rags of old opinions, physiological text-books drive more deeply the fastenings of error by elaborate chapters on the subject, and even the greatest of all English prizes is offered in the year of our Lord 1875 for an essay on the "Diseases of the Sympathetic Nervous System."

Surely, then, our readers will pardon our occupying a brief space with the discussion of this Old-World myth.

The name sympathetic is a highly suggestive one, redolent, in its mysterious, undefined comprehensiveness, of those mediæval days when "nature abhorred a vacuum." In itself it has been a priceless treasure to those who were determined to explain everything, and a stumbling-block in the way of those who, with the true humility of modern science, contend that it is better to leave the unknown as unknown than to theorize far beyond the known facts. It is so easy to talk grandiloquently concerning the sympathies of the organs and this wonderful net-work of nerves that permeates and unites them all. The offspring of error, the name has become the progenitor of error. But let this pass; accepting the appellation as hopelessly fixed by custom, let us inquire as to the existence of the thing named.

There are undoubtedly in various parts of the body certain anatomical structures—masses of ganglionic nerve-matter connected by nerves and giving off nerves—to which the term has been applied. The question is not, however, whether there are any structures, but whether these constitute a nervous system capable of independent action and having a unity of function.

A nervous system must of course contain afferent nerves running from the periphery to the centre, which receives their transmitted impulses, and sends them back through other nerves to the periphery again. A nerve and a ganglion do not form in themselves a nervous system, else the posterior roots of the spinal nerve and their ganglia are worthy of such dignity. Where, then, is the afferent nerve of the "sympathetic nervous system"? In the posterior spinal nerve-roots and their continuation as the ordinary nerves of sensation alone exist any nerve-fibres which are capable of transmitting a peripheral irritation so that it may reach the sympathetic ganglia. In other words, the afferent nerve of the so-called sympathetic system is a cerebro-spinal nerve passing up into the medulla oblongata. If this nerve and its connection be intact, an impulse started in its periphery passes up to the medulla, down again through the cord, out with an efferent cerebro-spinal nerve, and on through one or more of the so-called sympathetic ganglia to the vessels of the body, producing a contraction of them. If the spinal nerve be cut, if the spinal cord be divided, or if the efferent spinal nerve or the so-called sympathetic ganglion be injured, the impulse which has started at the periphery of an ordinary nerve is unable to reach the vessel and produce its

effect. In other words, there is here a true physiological nervous system,—the vaso-motor,—anatomically composed of an ordinary sensitive nerve, a portion of the cerebro-spinal axis, an efferent spinal nerve, and a sympathetic ganglion with its nerves. The so-called sympathetic nervous system forms merely a subordinate portion of this complete system, which is in its origin cerebro-spinal.

Nor is there in the sympathetic ganglia any unity of function. It has recently been established that there is a nervous system that controls calorification,—*i.e.*, nutrition or the chemical movements of the tissues,—independent of the circulation and respiration. If this is to be acted upon, it is an ordinary spinal afferent nerve that transmits the impulse to the chief centre of the system, which is placed somewhere at the base of the brain. The outward track of this impulse is down through the spinal column, out along the spinal nerves, and in all probability through the sympathetic ganglia to the various organs and tissues of the body.

Again, if the upper cervical sympathetic ganglion be divided, the iris contracts; if it be stimulated, the iris dilates; if the thoracic ganglia be injured, the heart manifests the result; and the intestinal movements are directly under the control of the splanchnics.

Evidently the so-called sympathetic ganglia are only portions of various physiological nervous systems, and are nothing but reinforcing nerve-masses situated upon the tracks of efferent nerves, corresponding, it may be, to the posterior spinal ganglia on the afferent nerves.

If we view the human organism from an anatomico-physiological stand-point, there is evidently but one nervous system,—namely, the cerebro-spinal,—since all centres in the cerebro-spinal axis; but if we adopt a purely physiological point of view, there are a number of nervous systems, all finding their centres within the cranium. Of several of these—the vaso-motor, the cardiac, the intestinal, and the chemical—the sympathetic ganglia evidently form a part. It will probably be found that these outlying nerve-masses are also connected with nervous systems not yet known. The only safe method of progress is, however, simply to make the best use of known facts, not to build theories out of the mere pasteboards of imagination. It is high time, therefore, that we ceased to speculate concerning the sympathetic nerves, discussing simply the influence of vaso-motor, chemical, and other nerves, and trying, by experiment, to discover what else of importance there is in that tangled bundle of possibilities, the so-called sympathetic ganglion.

DR. THOMAS G. MORTON has called upon us with reference to the recent editorial containing a quotation from his article in regard to the statistics of the Pennsylvania Hospital. He says that he believes that in certain states of the weather in summer there is no movement of the air, and consequently no ventilation, even if all the windows be open, and he claims that in the Pennsylvania Hospital the windows are not sufficiently large or abundant, and, moreover, are so high from the floor as to leave the lower strata of air to a certain degree, as it were, in a well,—a fact which first led him to advocate the forced ventilation. He also says that he has made calculations based on the statistics of forty-five years, which appear to show that the “apparent fallacy in the statistical argument” we pointed out is more apparent than real. Thus, dividing the year into two six months,—from May to November, and from November to May,—there have been in the forty-five years, during the winter months, 359 cases, with 86 deaths, giving a percentage of $24\frac{51}{100}$; during the summer months 522 cases and 143 deaths, yielding a mortality rate of $27\frac{20}{100}$ per cent. These figures speak for themselves. In regard to our not being able to consult the hospital records, it appears that during ten years Dr. Morton kept himself the only records of amputation, so that the hospital cannot show what it does not have,—a fact that does not speak in thundering notes of praise in favor of the organization or executive management of this portion of the hospital surgical service. The subject is rendered even more difficult by this want of public records; but, correct or incorrect, our editorial has been of service, since it has led Dr. Morton to promise us at some not far distant day a careful and elaborate paper on the subject.

MR. G. W. CALLENDER, F.R.S., a distinguished London surgeon and one of the staff of St. Bartholomew's Hospital, says in a letter to a surgical friend in this city that he will probably visit this country during the latter part of the coming summer. Mr. Callender is well known for his original surgical observations and as an able contributor to periodical medical literature, and the profession of America will be glad to extend courtesy to him.

At a meeting of the County Medical Society held just after the last number of the *Times* had gone to press, Dr. William Pepper brought forward a motion to invite the American Medical Association to meet in Philadelphia next year. After considerable discussion, in which it was quite plainly shown that the intention of some had been not to

take such action, it was decided unanimously to invite the Association, asking it at the same time, however, to postpone its meeting until June.

CORRESPONDENCE.

BALTIMORE, April 24, 1875.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

DEAR SIR,—For five days the attention of the medical profession was occupied by the meetings of the Medico-Chirurgical Faculty, which is our State Society. The sessions began on April 12, and terminated on the 17th. Much interest was shown in the proceedings, as was evident by the large attendance.

The regular reports presented by the officers and standing committees indicate that the faculty is in a flourishing condition. The report from the Library Board recommended adding late works to the collection of Noachian volumes now on hand, securing a pleasant reading-room, and the publication of a monthly journal. Everybody knows that it is an *extremely easy* matter to start a journal, but whether a resolution from any medical body can make it a success remains to be seen. The history of medical papers in this State has been so unfortunate that individuals and societies would do well to count the cost before making the venture.

The report on Surgery was presented by Prof. Thos. R. Brown.

Dr. J. M. Toner, of Washington, delivered the Annual Oration, on the Topography of Maryland as affecting Health. Regret was expressed that the facts collected by the U. S. Census bearing upon vital statistics have not been reported by the smaller political divisions of cities and counties, instead of merely by States and districts, as the omission impairs their usefulness for comparison. To meet the want, however, he presented a table prepared to show the full number of physicians employed in the State, and the extent of their fields of labor. In 1850 the population was 583,034, of whom 990 were physicians,—a proportion of one to every 588 of the population. The total mortality was 9621. In 1860 the population was 687,049, of whom 1093 were physicians, being one to every 628. The mortality was 7374. In 1870, population 780,894, physicians 1257, or one to 621. Mortality 9740. A lengthy description of the topographical and geological condition of the State was given, dwelling upon the malaria that infests certain portions. He thinks that drainage would relieve many parts of the State of this cause of disease. For this purpose he recommended that the legislature should be requested to appoint a competent civil engineer to act in conjunction with the State Board of Health, of which body he should be a member. He should make a complete survey of all the swampy, badly-drained, and water-soaked lands of the State, and suggest measures for abating the nuisance. The doctor closed his address by making a complete review of the various surveys made throughout the State, and warmly commended the western section as being as healthy a

region for summer resort as there can be found in the United States.

The report from the section of *Materia Medica* was presented by Prof. McSherry. He spoke at length on calomel as a cholagogue, quinine in the summer diseases of children, hæmatoxylon in membranous enteritis, kousso and sulphur in tapeworm, and ergot and phosphoric acid in some diseases of bladder and rectum.

Dr. G. H. Boyland read a paper on "Cases in Foreign Hospital-Practice." The cases were interesting; but why a paper made up of cases copied from medical journals should be read as an original paper I cannot see.

Prof. F. T. Miles and Dr. I. E. Atkinson both read papers of some interest.

"Tinnitus Aurium," by Dr. Theobald, was an interesting paper. He thinks that tinnitus is produced by the vibration of the walls of the blood-vessels, produced by friction of the circulating blood, which excites the terminal filaments of the auditory nerves.

Prof. Chew read a paper on "Digitalis in Heart-Disease."

The report on Obstetrics and Gynæcology, by Prof. W. T. Howard, was long and dry, and not very new. When I mention the fact that he kept the floor for three hours, you may know the audience was exhausted, if the subject was not.

The officers for the year are: President, Dr. J. F. Monmonier; Vice-Presidents, Drs. C. Johnston, A. B. Arnold, J. C. Thomas; Recording Secretaries, Drs. W. G. Regester and G. L. Taneyhill; Treasurer, Dr. J. Gilman. Chairmen of the Sections: Surgery, Dr. C. Johnston; Practice, Dr. A. B. Arnold; Obstetrics, Dr. W. T. Howard; *Materia Medica* and Chemistry, Dr. D. J. McKew; Meteorology, Dr. E. Lloyd Howard; Anatomy and Pathology, Dr. H. R. Noel; Psychology and Physiology, Dr. J. S. Conrad. Drs. N. P. Smith, J. F. Monmonier, John Morris, C. Johnston, F. Donaldson, J. J. Cockrill, A. Hartman, P. C. Williams, S. C. Chew, J. Gilman, A. B. Arnold, A. F. Erick, E. L. Howard, G. L. Taneyhill, F. T. Miles, H. R. Noel, W. G. Regester, T. S. Latimer, C. H. Jones, L. Ellicott, J. C. Thomas, J. A. Stewart, D. J. McKew, W. C. Van Bibber, T. R. Brown, R. Buckler, R. McSherry, and H. T. Rennolds were appointed delegates to the American Medical Association. The meetings of the Faculty have improved in interest very much with the last few years, but they might be much better if gentlemen could learn the art of condensing. Some of the memoirs were much longer than the subject justified, and many papers were, on account of want of time, referred to the Committee on Publication unread. I had intended to say something about the Johns Hopkins Hospital and University, but must defer it until next time.

Yours, etc.,
MEDICUS.

Harvard University now requires a preliminary examination, or its equivalent, before entrance of the medical department.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, FEBRUARY 25, 1875.

THE PRESIDENT, DR. H. LENOX HODGE, in the chair.

DR. H. S. SCHELL presented a specimen of *atresia vaginae*, which is reported in full in another column of the current number of the *Times*, together with the report of the Committee on Morbid Growths.

Dr. H. LENOX HODGE remarked that one point of practical interest was whether the aspiration had anything to do with causing death. He had himself many times passed a needle into the abdominal cavity, both from the vagina and through the abdominal walls, and had never had the slightest accident to result. He was glad to find that Dr. Schell did not ascribe the death of the patient to the aspiration, but to the peritonitis caused by the rupture of the cul-de-sac.

Dr. SCHELL said the examination was made under the influence of ether, of which a very large quantity was used,—more than a pound. The patient resisted etherization so violently that at one time a large portion of the tumor protruded through the anus, looking not unlike a child's head, and he thought it probable that at that time the rupture took place. There was no great force used by the surgeons in their manipulations, because rupture was anticipated.

Dr. HODGE further called attention to the band of tissue running through the sac of the vagina, separated and isolated from the surrounding structures, save at its extremities; also, to the fact that the Fallopian tube appeared to enter the uterus at one side near its middle, and at the other in its usual place.

Dr. SCHELL called attention to the interesting fact that the neck of the uterus was dilated much more than the body, whereas one would suppose that the body would be the portion most dilated in retained menses.

Dr. HODGE said he had had no experience in retained menses, but he had often heard his father express surprise at the little effect the retention seemed to have upon the uterus, and that in his cases the distention was almost entirely that of the vagina, while the uterus was very little enlarged, floating, as it were, above the blood. In this instance, however, not only the vagina, but the major part of the uterus also, was enlarged.

REVIEWS AND BOOK NOTICES.

A STUDY OF FEVER. The Toner Lecture for 1875. By HORATIO C. WOOD, M.D. Smithsonian Institution. (Kept on sale by J. B. Lippincott & Co. Price 25 cts.)

This pamphlet is as well worth reading by thoughtful physicians as anything which has lately passed under our eyes; and whether or not we differ with its able author as to his conclusions, no one can fail to feel that the argument is most intelligent, and that the experiments are devised by one who has a gift for research which needs only use to become of the utmost value to medicine. Dr. Wood wishes to prove that fever is heat and its consequences,—or that heat will cause all the phenomena of fever; that local application of heat causes such functional disturbances as are familiar to us in fever; that to lessen heat is, in fever, to relieve such functional symptoms. Then follow Dr. Wood's details of his former experiments on the fatal influence of heat. Here we want somewhat experiments on the prolonged subjection of animals to a moderate

heat; and we still lack throughout all the proof that artificially-induced fever increases the chemical products of the body, and that such products are akin in the fever of disease and that of the laboratory.

Dr. Wood next asks in what way the febrile rise of temperature is caused, and shrewdly puts the question on p. 12 as to hæmic or neurotic parentage for fever, concluding that there is a neural "fever-centre," and that it is this which is influenced, directly or indirectly, by so-called hæmic poisons. The discussion which follows as to like production of local fever and of urethral fever is especially interesting. Then comes a series of experiments to prove that the fall of temperature caused by irritation of a sensitive nerve is independent of the circulation,—that is, the change is not due to lessened blood-flow, and, if not, is due to direct influence of the nervous system upon the heat-producing function of the body. Dr. Wood next states the facts in sequence leading up to his own contributions. They are these: Section of the spinal cord in the neck causes—first, a slight fall, and then a rise of temperature to fever if the animal be kept warm,—as in a box or covered with cotton,—but unhurt animals so placed do not grow overheated. Section of cord between the medulla oblongata and the pons Varolii gives immediate rise and no fall of temperature. These latter facts rested on one experiment by Tscheschichin, and have been thoroughly reproven by Dr. Wood, who also seems to show pretty clearly that this operation leaves the vaso-motor centres in the medulla oblongata untouched, because they are below the point of section.

Dr. Wood concludes from these facts that the vasal disturbance has no share in the fever of spinal sections, as to which it is but just to add that so pregnant a conclusion can hardly be accepted without much more and much more varied evidence; nor will it be complete until, by some rapid means, as the thermo-multiplier, a rise in temperature after spine-section can be seen in limbs devoid of blood. If by an Esmarch bandage a limb were emptied of blood, and then found to rise in heat ever so little after spinal section, the case for a centre-controlling chemical activity, not alone through vasal dilatation and contraction, would be well made out.

In Dr. Wood's next corollary he follows Tscheschichin, and thinks with him that above the medulla oblongata must lie a centre capable of lessening chemical action, and, of course, with it the product of heat. As concerns this point, it may be well to remark that it is hard to get away from the idea of ordinary nutritive chemical activities, and that whoever deals with the question of the heat-making chemistry cannot escape from considering, in its relation to them, the questions as to nutritive centres, which, if they exist, must be more or less regulative of heat-product.

The remainder of this very able paper is chiefly taken up with illustrations from disease, meant to show how completely the idea of an inhibitory heat-centre explains its thermal phenomena. We are, however, not quite of Dr. Wood's opinion that cerebral rheumatism is "completely cleared up" by this theory. It is, of course, possible that rheumatism may fall on the centre in question and paralyze it; but the first effect ought to be, one would think, irritative, and should call out an explosion of inhibitive force which would be seen as lowering temperature, and only raise it when the palsy-point was reached. Then, also, it seems strange that no other brain-malady which affects these centres seems to create the enormous rise of temperature due to rheumatism. The difficulties which gather thick about this subject are admirably illustrated on p. 34 of a most masterly clinical paper upon cerebral rheumatism, by Prof. Da Costa, *American Journal of the Medical Sciences*, January, 1875.

Dr. Wood has certainly pointed thought in a new

direction, and has begun what we hope to see him complete, for no subject in the range of physiology promises more to a worker so ingenious and so fertile in experimental resources.

S. WEIR MITCHELL.

THE HISTOLOGY AND HISTO-CHEMISTRY OF MAN. By HEINRICH FREY. Translated from the Fourth German Edition by ARTHUR E. J. BARKER, Surgeon to the City of Dublin Hospital. New York, D. Appleton & Co.

The present volume is by no means a new acquaintance; it is rather an old friend in a new dress. We have long known the original German work as on the whole probably the best that exists for the use of the average medical practitioner, or the special student of the subject during his earlier studies. A somewhat cursory examination of the volume before us has led us to the opinion that the translator has done his work well. The printing and proof-reading also are good, and we can therefore commend the work most highly to the attention of our readers.

A COURSE OF LECTURES ON PHYSIOLOGY, as delivered by PROF. KUSS at the Medical School of the University of Strasbourg. Edited by MATHIAS DUVAL, M.D., formerly Demonstrator of Anatomy at the Medical School of Strasbourg, etc. Translated from the Second Revised Edition by ROBERT AMORY, M.D., formerly Professor of Physiology at the Medical School of Maine, etc. Illustrated by 150 wood-cuts inserted in the text. Boston, James Campbell, 1875.

We hail with pleasure the appearance of this work, as furnishing the first exposition in the English language of what may be termed the modern physiology. Notwithstanding the numerous text-books on this subject now extant, there is not one, with the exception of this just issued, which affords the student an opportunity of becoming familiar with the new aspect which physiology has acquired in the past ten years. Further, with few exceptions, the entire subject in its different departments is equally considered—no undue proportion of space being devoted to one to the exclusion of another—in little more than five hundred moderate pages, so that the student can easily compass its extent in the time allotted him.

The author very properly begins the first part with general physiology,—cellular physiology,—and, after a somewhat clumsy effort to define physiology, takes up *the cell*, which he indicates indifferently by the latter term and the word *globule*, to which we object emphatically. For although the correct notion of a cell in its active, growing state makes it anything else but "*a cell*" or *vesicle* in the strict sense of the word, and although it is really a clump or mass of *living* matter, the word *globule* has become so closely associated with a spherical mass of *dead* material either of microscopic size or larger, and, under the former circumstances, presenting such well-defined characters under the microscope,—those of a bright centre and dark outline, the width of the latter, being directly as the difference in the refractive index of the globule and the menstruum in which it floats,—that it seems like retrogression to reapply it to the "*elementary part*." While the term "*cell*" is also objectionable for the above reason, it is less so than the word "*globule*," because there is a period in the history of many cells at which they are *vesicular*, and it has, moreover, become so engrafted upon histology that there is some justification for its use. We much prefer, however, the term "*elementary part*," which not only does not clash with our present idea of the anatomy of the cell, but will also be in accord with any future modification of it.

The *second* part of the book is devoted to the nervous system; the *third*, to contractile elements,—muscles and

their appendages; the *fourth*, to the blood and its circulation; the *fifth*, to a general view of epithelial globules and epithelial surfaces; the *sixth*, to the *digestive system*; the *seventh*, to pulmonary mucous surface, respiration, animal heat, and phonation; the *eighth*, to the external integument; the *ninth*, to the organs of special sense; and the *tenth*, to the uro-genital system and embryology. In the last, the view adopted of the minute structure of the kidney is not that which seems clearly established by the latest researches of Ludwig and Henle, as well as the earlier ones of Todd and Bowman. By the author the Malpighian body is described as formed by a surrounding of the Malpighian tuft by the Malpighian capsule, in a *depression* of the capsule, the two surfaces of the latter being closely opposed, and the whole capsule folding over the tuft somewhat as the pleural sac embraces the lung, the afferent and efferent vessels bearing the same relation to the capsule as the root of the lung does to the pleural sac, instead of perforating it as is generally taught.

With regard to the secretion of urine, also, Küss adopts the somewhat singular view of Wittich, that it is a filtration of *all* the constituents of the liquor sanguinis, including the albumen, which is, however, re-absorbed by the epithelial cells of the uriniferous tubules beyond the Malpighian capsule. While there is no doubt that a large part of the act of secretion of urine is accomplished by the processes of filtration under pressure and of osmosis, we cannot believe that in health the albumen is forced through the walls of the blood-vessels as it is in disease; while we further prefer to adopt the intermediate ground, according to which the water and inorganic salts of the urine are obtained through filtration and osmosis; but the organic constituents, urea and allied substances, are added through a *secretory* action of the cells.

While all that we have said in favor of this work, to which we have devoted more than our usual amount of space, is strictly true, and while, on the whole, we find in it a book better adapted to the wants of the student than any other in the English language, yet it is far from being a perfect text-book, and in this we are glad that its able translator, Dr. Amory, agrees with us.

In the first place, as Dr. Amory says in his preface, too much prominence is given (we mean for the purposes of the student) to the author's peculiar views, to the exclusion of others; second, it lacks that clearness of expression and sharply-defined systematic arrangement which is so necessary for the student, while there is sometimes so much ambiguity in the language used that even those who have some knowledge of physiology cannot always arrive at the author's meaning. These are serious defects in a text-book. They may be, in part, due to the difficulties in translation. Of this we cannot be certain, as we have never seen the book in the original; but we think so practical a physiologist as Dr. Amory would have been justified in sacrificing literalness of translation to clearness of meaning.

A few errors which have escaped the proof-reader, such as the use of singular verbs with plural nominatives (p. 27), the substitution of the words "*spinal canal*" for "*spinal cord*" (p. 34 at end), and some others, we hope the translator may have an opportunity to correct in an early second edition.

J. T.

QUADRUPLETS.—The *Lyon Médical* states that the Countess Schlippenbach, in Croatia, was lately delivered of four children, three girls and one boy. A woman of the name of Latoche, of Saint-Roch, near Quebec, is also mentioned as having given birth to four fine boys. The paper does not state whether these children lived.

SELECTIONS.

SPECK ON DEATH FROM A RATHER HIGH TEMPERATURE.—C. Speck publishes a case in Eulenberg's *Vierteljahrsschrift für gerichtliche Medizin und öffentl. Sanitätswesen*, vol. xxi., quoted in *Centralblatt für die Medicinischen Wissenschaften*, Feb. 27, 1875, of death which he attributes to a high temperature. A girl aged seventeen, who had suffered for eight years from contractions of all her joints, was enveloped, as a remedial measure, in the skin of a sheep just killed, then surrounded with fresh-baked hot bread, and a covering thrown over all. She complained after an hour of feeling uncomfortable, and of pain, then sank into sleep, then had difficulty of breathing, and perspired a great deal; lastly, became pale, and died about three hours from the beginning of the 'cure.' The most marked feature of the necropsy was advanced decomposition, although the surroundings were not favorable to this. The finest vessels in the pia matter were injected, whilst the larger were almost empty of blood, but contained air [*sic*]. The heart and large vessels were almost bloodless; the pericardium contained frothy fluid. The walls of the heart were pulpy, and studded with punctiform ecchymoses. The medico-legal report was to the effect that, in the absence of any other cause of death, the advanced decomposition pointed to decomposition of the blood, and that death was probably due to the so-called 'cure.' Reference was made to the investigations of Bernard and Ackermann, showing the injurious effects of temperatures equalling or exceeding the normal temperature of the body. Speck satisfied himself that bread exposed to the air in a room at the temperature of 16° or 17° (60° to 62° Fahr.) had, after two hours, a temperature of 45° (113° Fahr.) in the interior. [The reporter thinks it far more reasonable to attribute this death to the carbonic acid, etc., given off from the bread, especially as he knows of a somewhat similar case which occurred in the country some years ago, when death, with all the signs of suffocation, followed from a similar procedure advised by a quack. It is also well known that accidents of this kind used to occur to journeymen-bakers some years ago. The empty condition of the heart and great vessels was, no doubt, due partly to the youth of the victim and partly to decomposition.—*Rep.*]—*W. Bathurst Woodman, M.D.*, in *London Medical Record*.

GLEANINGS FROM OUR EXCHANGES.

TREATMENT OF RHEUMATISM AND GOUT WITH TRIMETHYLAMIN.—Mr. W. H. Spencer contributes to *The Practitioner* (February and March) the results of his experience in the use of this remedy.

After giving a brief *résumé* of the chemical history and properties of the drug, he gives the notes of a number of cases, treated either with the somewhat impure trimethylamin (called propylamin in commerce) or with the synthetically-prepared chloride of trimethylamin. The dose employed varied much: it ranged from nine to thirty minims for the solution, and did not exceed ten minims for the salt.

As supporting the probability of variation in composition, Mr. Spencer, at different times, found that the same results were obtained with a dose of two minims as with a dose of eight. His method of administering the drug is in doses of four to eight minims, at first every hour or two hours, increasing the interval as the pains diminish and the case progresses. When all pain is gone he ceases to give the remedy, and substi-

tutes in most cases quinine. He rarely has to re-exhibit the trimethylamin, but does so if the pains recur. Mr. Spencer's cases are sixty in number, of which notes are given in twenty-one, including cases of acute and chronic rheumatism, gout, and gonorrheal rheumatism. In the latter, trimethylamin seemed to have only a temporary effect. In the others its effect was always beneficial,—sometimes remarkably so. The chloride failed in a number of cases, and the solution ("propylamin," so called) had to be substituted.

Continental observers have stated that under the influence of trimethylamin the amount of urine excreted is increased, whilst the amount of urea excreted is diminished. M. Bouchard found that one of the physiological effects of trimethylamin was diminution in the excretion of urea. It has been observed that a sudden and inexplicable increase in the amount of the urea excreted is liable to occur during the use of trimethylamin. All of these observations are confirmed by Mr. Spencer's experiments. Among the unfavorable effects of the remedy may be mentioned certain nervous symptoms and headache, occurring in some cases; in others, gastric disturbance and diarrhoea were brought on even while the remedy continued to do good. In one or two cases the use of trimethylamin seemed to exercise a pernicious effect upon certain intercurrent sores, causing sloughing, which was only healed when this drug was discontinued. The remedy appears to exercise but little influence on the course of the fever, as indicated by the thermometer, in opposition to the views of Continental observers. On the other hand, it appeared in many cases as if the cardiac symptoms were actually aborted.

THE VALUE OF TAR IN BRONCHIAL CATARRH AND WINTER COUGH.—Drs. Sidney Ringer and William Murrill contribute a note on the use of tar to the *British Medical Journal*, March 20. They have employed tar in two-grain doses, made into a pill, every three or four hours. From October to January inclusive its effects were watched on twenty-five patients, whose ages varied from 34 to 70. All these patients had suffered several years from winter cough, lasting the whole winter.

These patients suffered from paroxysmal and violent cough, each attack lasting from two to ten minutes,—recurring ten or twelve times in the day, and breaking their rest at night. Expectoration abundant, frothy, and purulent. Breathing short on exertion, but most could lie down at night without propping. The physical signs showed a variable amount of emphysema, with sonorous and sibilant rhonchus, and occasionally a little bubbling rhonchus at the base. These patients usually began to improve from the fourth to the seventh day; the improvement rapidly increased, and in about three weeks they were well enough to be discharged. The improvement was so decided that even those patients who, in previous years, had been confined to the house during the whole winter, returned to their work. On discontinuing the tar, relapses often occurred in a week or two, but on re-administering the medicine relief was again obtained.

TREATMENT OF NÆVI BY ELECTROLYSIS.—Dr. S. I. Knott reports (*Lancet*, March 20) a number of cases in which he has employed electricity in the removal of nævi from all parts of the body, with great success. He uses Stöhrer's and Meyer and Meltzer's continuous batteries, and judges, according to the size of the nævus, how many cells to use. Six or eight is about the average if the battery is in good working order. If the nævus is small he uses one or two needles attached to the negative pole, and one to the positive, and passes them into the tumor; but if large, he puts on several needles in the negative cord, and uses a charcoal point with the positive. After the needles have been in the

tumor a short time, decomposition begins to take place: this is shown by bubbles of gas passing by the side of the needles. A clot is then formed, the tumor turns of a bluish white, and in this clot fibrous degeneration takes place, and ultimate cure is the result. The advantages of the galvanism are its certainty of action, its safety, the faintness of the cicatrix, and the cessation of pain directly the operation is over.

Dr. Knott has used every other method, but thinks this is by far the best. His communication closes with the notes of thirteen cases, out of some forty upon which he has operated.

CASE OF COXITIS TREATED BY EXCISION.—The following case is reported by Mr. Hulke in the *Lancet*, March 20. A lad of 19 was admitted into the Middlesex Hospital, with coxitis of about twelve years' duration. The left lower extremity was very much wasted, the thigh strongly flexed and adducted, and very firmly anchylosed to the pelvis. He complained much of pain in the knee and hip, aggravated by the least attempt at passive movement or pressure on the hip. The leg was flexed at about 90°, and the knee contracted. The left thigh was fourteen inches long, the right, seventeen and a half inches. There were scars of former abscesses about the hip. The disease dated back to a fall twelve years previously. Various abscesses formed from the time of his admission, March 6, 1874, until May 6. At that time resection of the head of the femur was performed, a drainage-tube was inserted into the acetabulum, and the wound closed, after having been washed out with chloride of zinc. The bent knee did not allow the application of a splint; extension and fixation were therefore maintained by straps, cord, and weight. The patient rallied slowly, and lingered through the summer until October, when it was decided that his only chance lay in an amputation at the hip-joint. This operation was therefore performed; lateral skin-flaps being cut from without and reflected, and then the muscles divided, circularly, close to the face of the pelvis (Guthrie's method). The wound healed kindly, and the patient still survives, March 20, 1875, with a good chance of ultimate recovery.

LADIES' RETIRING-ROOMS IN LONDON.—A company has been formed in London for the purpose of establishing ladies' retiring-rooms. It having been suggested in the *Lancet* that certain risks would be run at such establishments, the secretary writes to the editor of that journal as follows:

"SIR,—The gentlemen who have associated themselves to form a company for the purpose of establishing ladies' retiring-rooms, etc., are much indebted to you for the notice of their project which you were pleased to give in your issue of January 16. With reference to your concluding remark as to the risk which ladies might run of contracting a contagious disease, those gentlemen would be glad of an opportunity of stating in your columns, for the information of 'parents and husbands,' what they could not very well set forth in their printed scheme,—namely, that it will be insisted on that the matron in charge will see, immediately, after any closet is used, that it is well cleansed and dried, and in all respects made fit for subsequent use. In order that this may be effectively carried out, as large a number of closets as possible will be fitted up at each of the resting-places. Moreover, it is in contemplation to introduce more than one description of convenience, and large sheets of paper will be provided for placing over the seats if desired, and other similar provisions will be made. For example, a large number of *false seats* might be prepared at comparatively small cost, very light, and capable of being readily washed all over, so as to allow of a perfectly clean and dry seat being available for each visitor. The

main seat of each closet will be of highly-polished wood, probably mahogany, and glazed tiles will be very freely employed. The gentlemen associated with me are well assured that the success of the undertaking will depend in great measure upon one thing, and that is *cleanliness*. With thanks on their behalf,

"I remain sincerely yours,

"TOM NICHOLS,

"Hon. Sec. to the proposed Company."

TREATMENT OF FRACTURED PATELLA.—*The Practitioner* for March contains three short communications on this subject, by as many surgeons. Mr. Spence recommends a modification of Malgaigne's hooks, these being fastened in strips of moleskin adhesive plaster cut out carefully to fit the skin, and attached above and below the knee. By this means the irritation caused by inserting the hooks into the live integument is avoided.

Mr. Callender, of St. Bartholomew's Hospital, treats fracture of the patella by a peculiar arrangement combining the swinging splint with the pulley and weight. The latter is attached to plaster strips, fastened below and above the knee, so that its weight pulls them together. Cuts are given illustrating both these plans of treatment. The third method, called the "expectant," is advocated by Mr. McGill, Surgeon to the Leeds Public Dispensary, as Mr. Teale's treatment. Mr. Teale simply places the leg on a pillow slightly bent between sand-bags, or on a straight splint, with the heel slightly raised, and the patient is confined to bed for six or eight weeks, and then when allowed to get up is fitted with a soft leather splint, which will limit but not arrest the movement of the joint. Mr. McGill advocates a somewhat similar treatment for fracture of the olecranon, using a rectangular splint.

SUCCESSFUL LIGATION OF THE COMMON CAROTID.—Dr. N. B. Kennedy (*Am. Med. Weekly*, April 10) was called to see a man, sixty-three years of age, who had, with suicidal intent, taken two ounces of laudanum, and a few hours later cut his throat with a pocket-knife. On examination, a transverse wound was found, about two and a half inches in length, extending from near the trachea to the outer border of the sterno-cleido-mastoid muscle of the right side. The common carotid artery had been severed at a point just below where it is crossed by the omo-hyoid muscle. The sheath of the artery had been opened for an inch or more; the descendens noni nerve and jugular vein were uninjured. A single ligature was passed around the vessel with the aid of an aneurism-needle, and tied with a double knot; one end being then cut off, and the other allowed to hang out of the wound. The external wound was closed by three interrupted sutures, and cold-water dressings were applied. The patient made a remarkably rapid recovery. On the morning subsequent to the operation he rose and dressed himself, declaring that he felt well, but weak; on the third day he went out riding, and the complete cure was effected in a very short time.

ERGOTIN IN FIBROID OF THE UTERUS.—Dr. Bartholow (*The Clinic*, January 23) had recently under his care a case of submucous fibroid of the uterus, for the cure of which he resorted to the hypodermic injection of an aqueous solution of ergotin in one-grain doses night and morning. On the afternoon following the injection the patient began to feel expulsive pains, which continued to increase in severity. After two weeks the injections were practised only once daily.

One week later the pains had diminished in severity, and, on examination, the neck of the uterus was found very much dilated and plugged with a tumor, which was then easily removed by the *écraseur*. The patient fully recovered, and has suffered none since the removal.

NOTES AND QUERIES.

FAILURE OF CHLORAL IN PUERPERAL CONVULSIONS.

WATSONTOWN, PA., April 17, 1875.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

Not long since, a number of physicians, through *The Medical Times*, claimed priority in the use of hydrate of chloral for puerperal convulsions, and, impressed by the tone of these claims, I judged we had a specific for the malady.

Several weeks ago I had the misfortune to have a patient attacked, three hours after delivery, with convulsions, violent and frequent (every half-hour regularly). I gave her at once twenty grains hydrate chloral. In half an hour I gave her thirty-five grains more, and in about an hour repeated the thirty-five grains, all of which had no effect on the frequency or severity of the paroxysms. In about eight hours I gave her thirty-five grains more without effect. In from one to two hours thereafter they suddenly ceased without any apparent cause, unless from an application of mustard to the spine, and the patient recovered. The patient was stout, hearty, plethoric, but had flooded considerably after delivery, and was somewhat exhausted.

The only case besides this one I ever treated seemed to yield to morphia and chloroform, while in this I think hydrate of chloral failed utterly. Or was it from an ignorant and limited use made of it? If so, I would be obliged for a hint to that effect. Taking this community, I think I can find at least five women who have survived convulsions for every one who died with them,—all this from varied treatment. Can any of the above aspirants give us an experience where chloral has cured a greater proportion? and, if not, on what do they base its happy effect?

J. J. LEISER.

CANINE SAGACITY, IN A SURGICAL CONNECTION.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

DEAR SIR,—In a letter recently received from Lancaster, where my father resides, it is said:

"A queer thing occurred just now. Father was in the office, and heard a dog yelping outside the door; he paid no attention until a second and louder yelp was heard, when he opened it, and found a little brown dog standing on the step upon three legs. He brought him in, and, on examining the fourth leg, found a pin sticking in it. He drew out the pin, and the dog ran away again."

The office of my father, Dr. Atlee, is not directly on the street, but stands back, having in front of it some six feet a stone wall with a gate. I will add that it has not been possible to discover anything more about this dog.

This story reminds me of something similar that occurred to me while studying medicine in this same office nearly thirty years ago. A man named Cosgrove, the keeper of a low tavern near the railroad-station, had his arm broken, and came many times to the office to have the dressings arranged. He was always accompanied by a large, most ferocious-looking bull-dog, that watched me most attentively, and most unpleasantly to me, while bandaging his master's arm. A few weeks after Cosgrove's case was discharged, I heard a noise at the office-door as if some animal was pawing it, and, on opening it, saw there this huge bull-dog, accompanied by another dog that held up one of its front legs, evidently broken. They entered the office; I cut several pieces of wood and fastened them firmly to the leg with adhesive plaster, after straightening the limb. They left immediately. The dog that came with Cosgrove's dog I never saw before nor since.

WALTER F. ATLEE.

TREATMENT OF NASAL POLYPI.

BALTIMORE, April 21, 1875.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

DEAR DOCTOR,—I was pleased to see an article in No. 181, current volume of the *Medical Times*, on "Muriet's Tincture of Iron as a Cure for Nasal Polypi," by my esteemed friend and former colleague, Prof. George Troup Maxwell, M.D., of New Castle, Del. I am able to bear corroborative testimony to its great value in that regard, from my personal observation of its action in destroying and preventing a return of the trouble. The first case in which I used the tincture of iron in the treatment of nasal polypus was that of George Wilson, Esq., of Savannah, Georgia, in 1859, on whom the operation of evulsion had been performed several times, with, as is often the case, only temporary benefit, the polyps returning after each operation in increasing volume, notwithstanding the greatest care in their removal and the most approved subsequent treatment. The patient was a young and healthy man, and had about given up all hope of the radical

cure of his trouble, when the iron-treatment was decided upon. The suggestion for its use, if my memory serves me correctly, came from my friend Dr. Maxwell. The iron in full strength was applied by a camel's-hair brush to the polyps nearest the external nares, and injected; when those came away, diluted one-half to one-third; and retained in contact with those farther on for a minute or two once a day. In a few days every vestige of the trouble disappeared, never to return again. In my hospital experience during our late civil war, several opportunities were afforded for testing the efficacy of this treatment, and always with success.

Very truly yours,

HARVEY L. BYRD, M.D.

THE attention of the municipal authorities, of the censors of the county medical society, or of the proper person or persons, whoever they may be, is called to the following local, taken from a Chambersburg paper. It ought to be ascertained whether the "doctor" complies with the law in Philadelphia:

"WITHDRAWAL OF APPOINTMENTS.—Owing to the recent law which passed the last legislature (approved by the Governor on Tuesday last), regulating the practice of medicine in Pennsylvania, Dr. Darmon has been compelled to withdraw his appointments with patients in this county. He will, however, he requests us to state, continue to treat patients by letter in all parts of the country, if they will send him a description of their cases, as cheaply as if he were present. His address is Wm. Darmon, M.D., No. 1824 Camac Street, Philadelphia."

ERRATUM.

For *urine*, in the account of Neubauer's experiments on salicylic acid, page 376, read *wine*.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM APRIL 20, 1875, TO APRIL 26, 1875, INCLUSIVE.

MCCORMICK, CHAS., SURGEON.—Granted leave of absence for four months, with permission to go beyond sea. S. O. 69, A. G. O., April 19, 1875.

SLOAN, WM. J., SURGEON.—When relieved by Surgeon Head, to report to Commanding General, Department of Dakota, for duty as Medical Director. S. O. 73, A. G. O., April 23, 1875.

HEAD, J. F., SURGEON.—To report to the Commanding General, Department of the South, for duty as Medical Director. S. O. 73, c. s., A. G. O.

HAMMOND, J. F., SURGEON.—Granted leave of absence for one month on Surgeon's Certificate of Disability. S. O. 67, A. G. O., April 15, 1875.

BYRNE, C. C., SURGEON.—Transferred from Willet's Point, New York Harbor, to Department of Dakota. S. O. 73, c. s., A. G. O.

FRANTZ, J. H., SURGEON.—Transferred from Department of the South to Military Division of the Atlantic. S. O. 73, c. s., A. G. O.

GIBSON, J. R., ASSISTANT-SURGEON.—Transferred from Department of the South to Department of the Platte. S. O. 73, c. s., A. G. O.

KINSMAN, J. H., ASSISTANT-SURGEON.—Leave of absence extended one month. S. O. 62, Department of Dakota, April 15, 1875.

O'REILLY, R. M., ASSISTANT-SURGEON.—Relieved from duty in Department of the Platte, to report to the President of the Army Medical Board, New York City, for examination for promotion, and, upon its completion, by letter to the Surgeon-General. S. O. 73, c. s., A. G. O.

WHITE, R. H., ASSISTANT-SURGEON.—Leave of absence extended six months, with permission to go beyond sea. S. O. 67, c. s., A. G. O.

ELBREV, F. W., ASSISTANT-SURGEON.—Assigned to duty at Lebanon, Kentucky. S. O. 52, Department of the South, April 21, 1875.

MATTHEWS, W., ASSISTANT-SURGEON.—Transferred from Military Division of the Atlantic to Department of California, and, prior to his departure, to report in person to the President of the Army Medical Board, New York City, for examination for promotion. S. O. 73, c. s., A. G. O.

MUNN, C. E., ASSISTANT-SURGEON.—Transferred from Military Division of the Atlantic to Department of the Platte. S. O. 73, c. s., A. G. O.

COWDREY, S. G., ASSISTANT-SURGEON.—Relieved from duty in the Department of the Missouri, to report to the President of the Army Medical Board, New York City, for examination for promotion, and, upon its completion, by letter to the Surgeon-General. S. O. 73, c. s., A. G. O.

SKINNER, J. O., ASSISTANT-SURGEON.—Leave of absence extended one month. S. O. 69, c. s., A. G. O.

FINLEY, J. A., ASSISTANT-SURGEON.—Transferred from Military Division of the Atlantic to Department of the Missouri. S. O. 73, c. s., A. G. O.

BEDAL, S. S., ASSISTANT-SURGEON.—Transferred from Military Division of the Atlantic to Department of Texas. S. O. 73, c. s., A. G. O.

HAMILTON, J. B., ASSISTANT-SURGEON.—Transferred from St. Louis Barracks, Missouri, to Department of the Columbia. S. O. 73, c. s., A. G. O.